STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPL	
		155491	B. WIN			02/24/2	011
NAME OF F	PROVIDER OR SUPPLIER	3		STREET	ADDRESS, CITY, STATE, ZIP CODE		
			1029 EAST 5TH STREET				
LINCOLN	N CENTERS FOR R	REHABILITATION AND HEALTHC	ARE	CONN	ERSVILLE, IN47331		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	BETTELENETY		DATE
F0000	This visit was	for the Investigation	F00	00	Preparation or execution of th		
	of Complaint	IN00085926.			plan of correction (POC) does constitute an admission or ass		
	•				by the provider to the truth,	JOIN	
	Complaint IN(00085926 -			accuracy or veracity or the		
	Substantiated,				alleged or conclusions set fort the Statement of Deficiencies	h in	
	· ·				(SOD). The POC is prepared		
	deficiencies re				and executed solely because		
	~	e cited at F223, F225,			required under law. Lincoln Centers for Rehabilitation and		
	F226 and F28	1.			Healthcare acknowledges rec		
					of the SOD and alleges that it	-	
	Survey dates:	February 23, and 24,			in compliance. Accordingly, th	е	
	2011				POC is submitted as alleged compliance as of March 25, 20	N11	
					Compliance as of March 25, 2	J11.	
	Facility number	er: 000316					
	Provider numb						
	AIM number:	100286370					
	Survey team:	Barbara Gray RN					
	Census bed ty	pe:					
	SNF/NF: 104	_					
	Total: 104						
	101111. 107						
	Canque pover	tuna:					
	Census payor						
	Medicare: 13						
	Medicaid: 80						
	Other: 11						
	Total: 104						
					!		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

CG2511

Facility ID:

000316

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) N	MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAIN	OF CORRECTION	155491		ILDING		02/24/2	
			B. WI		ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF P	ROVIDER OR SUPPLIER			1	AST 5TH STREET		
		EHABILITATION AND HEALTHC	ARE	CONNE	ERSVILLE, IN47331		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
	Sample: 3						
	.						
	These deficien	icies also reflect state					
		cordance with 410					
	IAC 16.2.	cordance with 410					
	1110 10.2.						
	Quality review com RN.	pleted 3/1/11 by Jennie Bartelt,					
	Terv.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155491	B. WIN			02/24/2011
	PROVIDER OR SUPPLIER	EHABILITATION AND HEALTHCA		STREET A	ADDRESS, CITY, STATE, ZIP CODE AST 5TH STREET ERSVILLE, IN47331	
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
F0223		rvation, interview,	F02	23	F 223 SS: D Free From Abuse/Involuntary Seclusion	03/25/2011
SS=D	and record rev	iew, the facility			is the policy of this facility to	'"
	failed to ensur	e the resident was			comply with regulatory	
	free of physica	al abuse, in that the			requirement Free From	4.
		atheterized by a nurse			Abuse/Involuntary Seclusion. Resident A was re-assessed b	•
		•			Social Services and appropria	· I
	_	mpaired for 1 of 3			actions were taken at the time	
	residents revie				Disciplinary action of staff was	
	allegations of	abuse in a sample of			also completed as appropriate time. 2.) Facility has conducted	
	3. (Resident #	² A)			review of a random sample of	u a
					charts and resident interviews	to
	Findings inclu	de:			ensure residents have remaine	ed
	i mamgs mera	de.			free from Abuse. 3.) Staff has been re-educated on the facilit	
	5				policy and procedure related to	
		as observed lying in			abuse prevention, reportable	
	bed on 2/23/11	1 at 3:48 P.M.			occurrences and drug testing	
	Resident #A h	ad facial features of			policy. DON/SSD or designee QA monitor abuse through	will
	Down's Syndro	ome and was			random alert and oriented	
	_	e when spoken to.			interviewable resident interview	ws
	non responsive	e when spenen to.			daily excluding weekends and	
	D: 1 4 # A !				holidays x 4 weeks, weekly x 4 weeks, then monthly x 2 month	
		record was reviewed			4. Results of QA reviews will	
	on 2/23/11 at 1	11:10 A.M.			forwarded to the Facility Risk	
	Diagnoses incl	luded, but were not			Management Quality Initiative,	
	limited to, Dov	wn's Syndrome and			(RMQI), for further evaluation	
	mental retarda	•			recommendations acted on as indicated. 5.) Allegation of	
					Compliance: March 25, 2011.	
	Resident #A's	significant change				
		a Set assessment,				
		ŕ				
		indicated Resident				
	#A had unclea	r speech, rarely/never				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155491				ULTIPLE CO LDING	NSTRUCTION	(X3) DATE S COMPLI 02/24/20	ETED
		100491	B. WIN			02/24/20) I I
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
LINCOLN	N CENTERS FOR R	EHABILITATION AND HEALTHO	CARE		ERSVILLE, IN47331		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
		ners, was rarely/never	1				
		quired extensive					
	assistance of t	wo persons for bed					
	mobility, requ	ired total dependence					
	on 2 persons to	o transfer, did not					
	walk, required	total dependence on					
	2 persons to di	ress, required total					
	dependence or	2 persons to toilet,					
	· ·	s incontinent of					
	bowel and blace	dder.					
	1	ncident on 2/7/11 at					
		vided by the Director					
		2/23/11 at 1:30 P.M.,					
		following facility					
	_	Description of					
		Director of Nursing					
	(DoN) receive						
		aff #1, indicating					
	1 * *	red impaired. The					
		t the East facility					
	_	obtained a urine drug					
		PN #2. The drug					
	temperature ra	reach the required					
	temperature st	-					
	_	W#2 drink something					
	_	vide another urine					
	in order to pro	vide another arms					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE COMPL		
THIS TETAL	or conduction	155491	1	LDING		02/24/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF F	PROVIDER OR SUPPLIER				AST 5TH STREET		
LINCOLN	I CENTERS FOR R	EHABILITATION AND HEALTHO	ARE	CONNE	ERSVILLE, IN47331		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	sample. While	e waiting on LPN #2,					
	the DoN receiv	ved a message from					
	confidential st	aff#3, indicating					
	LPN #2 had ca	atheterized Resident					
	#A in order to	obtain a urine					
	sample. Appre	oximately 20 minutes					
	later, LPN #2	reported to the DoN					
	to provide ano	ther urine sample.					
	When LPN #2	provided the DoN					
	her urine samp	ole, the DoN					
	questioned LP	N #2 about the					
	possibility the	urine sample was					
	actually obtain	ned from Resident					
	#A. At first L	PN #2 denied the					
	allegation, the	n finally admitted the					
	allegation was	true, stating she					
	"knew it was v	wrong and didn't					
	know what els	e to do". The DoN					
	informed LPN	#2 to count off her					
	narcotic medic	cations and gather her					
	belongings to	leave. The DoN					
	remained with	LPN #2 until she left					
	the building.	Гуре of					
	injury/injuries	- The resident was					
	assessed, and a	no redness,					
	discoloration,	or edema present.					
	The resident sl	howed no change in					
	mood or behave	vior. Immediate					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155491				ULTIPLE CO LDING	ONSTRUCTION	COMPL	ETED
		155491	B. WIN			02/24/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
LINCOLN	N CENTERS FOR R	EHABILITATION AND HEALTHO	CARE	1	AST 5TH STREET ERSVILLE, IN47331		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LPN #2 was escorted		TAG	DETELLACT		DATE
		ding by the DoN.					
		neasures taken - The					
	_	ted. The resident had party to notify. LPN					
	1 *	ated. LPN #2 would					
	_	the Professional rd. The first urine					
	_	om LPN #2 would be					
	sent for labora						
		yould continue to be					
		signs and symptoms					
	· ·	act infection, and					
		od or behavior, and re-educated on the					
	1	e and drug testing					
	policy.						
	An interview v	with the DoN on					
		P.M., indicated					
		red at the East facility					
		vening of 2/7/11, she					
	1	#2 in the conference					
	_	vided her with a urine					
	_	p. The urine drug					
	_	ed by LPN #2 did not					
	_	ired temperate on the					
	iemperature st	rip. She gave LPN					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	ONSTRUCTION	(X3) DATE COMPL	ETED	
		155491	B. WIN			02/24/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE AST 5TH STREET	•	
LINCOLN	CENTERS FOR R	EHABILITATION AND HEALTHO	CARE	CONNE	ERSVILLE, IN47331		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	#2 a dollar, an	d requested she get					
	something to d	lrink, to help her					
	urinate. The I	OoN indicated LPN					
	#2 also wanted	to smoke. The DoN					
	went to the Wo	est facility building to					
	obtain another	urine drug screen.					
		med to the East					
		ng conference room					
		LPN #2 to return,					
	1 1	nother drug screen.					
		N waited on LPN #2					
		e conference room					
		text message from					
		aff #3, LPN #2 had					
		esident #A to obtain					
	_	e. LPN #2 returned to					
		room, took the urine					
	_	om the DoN, went to					
		and returned with a					
	_	After several minutes					
		n, LPN #2 admitted					
	she had straigh						
		use for her urine					
	drug screen.						
	The most own	ant abusa nalisy					
		ent abuse policy					
		e Administrator on					
	2/23/11 at 10.3	30 A.M., indicated					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155491			ULTIPLE CO LDING	NSTRUCTION	(X3) DATE COMPL 02/24/2	ETED	
		155491	B. WIN			02/24/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
LINCOLN	CENTERS FOR R	EHABILITATION AND HEALTHO	ARE		ERSVILLE, IN47331		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	the following:	Overview - The					
	facility has im	plemented processes					
	that include th	e seven components					
	of abuse preve	ention and					
	management:	screening, training,					
	prevention, ide	entification,					
		restigation, and					
	reporting Pr	revention - 1.) Ensure					
	that prevention	n techniques are					
	implemented i	n the facility					
	including, but	not limited to:					
	Ongoing super	rvision of employees					
	through visual	observation of care					
	delivery 2.)	Identify, correct, and					
	intervene in si	tuations where abuse,					
	neglect, and/or	r mistreatment are					
	most likely to	occur Protection -					
	1.) Provide fo	r the immediate					
	safety of the re	esident/patient upon					
	identification of	of suspected abuse,					
	neglect, mistre	eatment, and/or					
	misappropriati	ion of property					
	This federal ta	g is related to					
	Complaint IN(-					
	3.1-27(a)(1)						
	` / ` /						

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPI		
		155491	B. WING 02/24/2011					
NAME OF I	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
					AST 5TH STREET			
LINCOLN	I CENTERS FOR R	EHABILITATION AND HEALTHC	ARE	CONNE	ERSVILLE, IN47331			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	 	TAG	DEFICIENCY)		DATE	
							<u> </u>	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED
		155491	B. WING			02/24/2011
			P. (12)		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				AST 5TH STREET	
	CENTERS FOR R	EHABILITATION AND HEALTHC	ARE	CONNE	ERSVILLE, IN47331	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	F02	TAG		DATE
F0225		ation, interview, and	F02	25	F 225 SS: D Investigate/Report Allegations/Individuals	03/25/2011
SS=D		e facility failed to protect			It is the policy of this facility to	
		buse by a nurse alleged to			comply with Investigating and	
	be working impa	ired during investigation			Reporting Allegations.	
	of the allegation.	The deficient practice			1.) Resident A was re-assessed by	/
	affected 1 of 3 re	sidents reviewed related			Social Services and appropriate	
	to the allegation	of abuse in a sample of 3.			actions were taken at the time.	,
	(Resident #A).	-			Disciplinary action of staff was a	•
					completed as appropriate at time.	
	Findings include	:			2.) Facility has conducted a	
					review of a random sample of	l l
	Resident #A was	observed lying in bed on			charts and resident interviews	
		P.M. Resident #A had			ensure residents have remained free from Abuse.	ea
		ne facial features, and was			liee nom Abuse.	
	non-responsive v				3.) Staff has been re-educated	l on
	non responsive v	viien spoken to.			the facility policy and procedur	re e
	Posidont #A's roa	cord was reviewed on			related to abuse prevention,	
		A.M. Diagnoses			reportable occurrences and dr testing policy.	ug
		_			DON/SSD or designee will QA	
		re not limited to, Down's			monitor abuse through randon	
	Syndrome and m	ental retardation.			alert and oriented interviewabl	l l
					resident interviews daily exclu-	ding
	Resident #A's sig				weekends and holidays x 4	
		Set assessment, dated			weeks, weekly x 4 weeks, ther monthly x 2 months.	1
	-	d Resident #A had			monuny x 2 monuns.	
	•	arely/never understood			4. Results of QA reviews will I	pe
		y/never understood,			forwarded to the Facility Risk	
	required extensiv	ve assistance of two			Management Quality Initiative,	
	persons for bed n	nobility, required total			(RMQI), for further evaluation and recommendations acted of	un.
	dependence on 2	persons to transfer, did			as indicated.	""
	_	d total dependence on 2				
	persons to dress,				5.) Allegation of Compliance:	
	•	persons to toilet, and			March 25, 2011.	
	_	ntinent of bowel and				
					<u> </u>	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ULTIPLE CO LDING	NSTRUCTION	(X3) DATE COMPL	ETED
		155491	B. WIN	IG		02/24/2	011
	PROVIDER OR SUPPLIER	EHABILITATION AND HEALTHO	CARE	1029 E	ADDRESS, CITY, STATE, ZIP CODE AST 5TH STREET ERSVILLE, IN47331	•	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	bladder.						
	A copy of an incip. P.M., provided by on 2/23/11 at 1:3 following facility. Description of In Nursing (DoN) reconfidential staff appeared impaired the East facility burine drug screen screen did not reatemperature rang strip. The DoN resomething in ord urine sample. We the DoN received confidential staff had catheterized obtain a urine samminutes later, LP DoN to provide a When LPN #2 prurine sample, the about the possibiliactually obtained first LPN #2 dentification for the composition of the composit	cident - The Director of eccived a call from S#1, indicating LPN #2 ed. The DoN arrived at building, and obtained a from LPN #2. The drug each the required e on the temperature requested LPN #2 drink er to provide another hile waiting on LPN #2, d a message from S#3, indicating LPN #2 Resident #A in order to mple. Approximately 20 eN #2 reported to the another urine sample. Foo ided the DoN her E DoN questioned LPN #2 lity the urine sample was a from Resident #A. At ided the allegation, then the allegation was true, or it was wrong and didn't					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CG2511 Facility ID:

000316

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/24/2011		
			D. WII		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	{		1029 E	AST 5TH STREET		
LINCOLI	N CENTERS FOR F	REHABILITATION AND HEALTH	CARE	CONNE	ERSVILLE, IN47331		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		remained with LPN #2					
		building. Type of					
	1 " " "	The resident was					
		redness, discoloration, or					
	1 ^	The resident showed no					
		or behavior. Immediate					
		PN #2 was escorted out of					
	1	he DoN. Preventative					
		The MD was updated.					
		no responsible party to					
	1 -	was terminated. LPN #2					
	1 ^	ed to the Professional					
		. The first urine drug					
		N #2 would be sent for					
	I	g. Resident #A would					
		onitored for signs and					
	1 * *	rinary tract infection, and					
		l or behavior, and staff					
		cated on the facility's					
	abuse and drug t	esting policy.					
	An interview wi	th the DoN on 2/23/11 at					
		ated when she arrived at					
	· ·	building the evening of					
	1	with LPN #2 in the					
	·	and provided her with a					
		n cup. The urine drug					
		by LPN #2 did not reach					
	1 ^	perate on the temperature					
		LPN #2 a dollar, and					
		t something to drink, to					
		The DoN indicated LPN					
	_	o smoke. The DoN went					
	•						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPL	ETED
		155491	B. WIN			02/24/20	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				AST 5TH STREET		
LINCOLN	N CENTERS FOR R	EHABILITATION AND HEALTH	CARE	1	ERSVILLE, IN47331		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	to the West facility building to obtain another urine drug screen. The DoN returned to the East facility building conference room and waited on LPN #2 to						
	return, and provide another drug screen.						
	_	vaited on LPN #2 to					
	return to the conf						
		essage from confidential					
		had catheterized resident					
	· ·						
	#A to obtain a urine sample. LPN #2 returned to the conference room, took the						
	urine drug screen from the DoN, went to the bathroom and returned with a urine						
	sample. After se						
	· ·	N #2 admitted she had					
	straight catheteri	zed Resident #A to use					
	for her urine drug	g screen.					
	An interview wit	th the DoN on 2/24/11 at					
	10:00 A.M., indi	cated she should have					
	stayed with LPN	#2 until she provided the					
	second urine dru	g screen. The DoN					
	1	2 needed to get something					
		nted to smoke, and that is					
	l '	t LPN #2 would be doing					
		o the West building to get					
	another drug scre						
	anomer drug sere	.011.					
	The most current	abuse policy provided					
		rator on 2/23/11 at 10:30					
	*						
	· ·	the following: Overview					
	l	implemented processes					
	that include the s	seven components of					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155491		A. BU	JILDING	NSTRUCTION	(X3) DATE COMPI 02/24/2	LETED	
		155491	B. WI			02/24/2	.011
NAME OF F	PROVIDER OR SUPPLIEF	t .		1	ADDRESS, CITY, STATE, ZIP CODE		
LINCOLN	N CENTERS FOR F	REHABILITATION AND HEALTH	CARE		AST 5TH STREET ERSVILLE, IN47331		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		and management:					
	screening, training	• •					
		otection, investigation,					
		Prevention - 1.) Ensure					
	that prevention to	-					
	_	the facility including, but					
		Ongoing supervision of					
		gh visual observation of					
		2.) Identify, correct, and					
		ations where abuse,					
	-	nistreatment are most					
	1 *	Protection - 1.)					
		mmediate safety of the					
	_	upon identification of					
		neglect, mistreatment,					
	and/or misappro	priation of property					
	This federal tag	is related to Complaint					
	IN00085926.	•					
	3.1-28(d)						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPL	ETED
		155491	B. WING			02/24/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			1029 E	AST 5TH STREET		
		EHABILITATION AND HEALTHCA	ARE .		ERSVILLE, IN47331		
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
		<u> </u>	F02	TAG		nnt .	DATE
F0226		ation, interview, and	F02	26	F 226 SS: D Develop/Implement Abuse/Neglect, etc Policies It is		03/25/2011
SS=D		e facility failed to follow			the policy of this facility to com		
		tecting residents from			with Developing and	,	
		alleged to be working			Implementing Abuse/Neglect,	etc	
		investigation of the			Policies.1.) Resident A was		
	_	deficient practice affected			re-assessed by Social Service and appropriate actions were	s	
		eviewed related to			taken at the time. Disciplinary		
	allegations of abo	use in a sample of 3.			action of staff was also comple		
	(Resident #A).				as appropriate at time. 2.) Fac	ility	
					has conducted a review of a		
	Findings include: Resident #A was observed lying in bed on				random sample of charts and resident interviews to ensure		
					residents have remained free		
					from Abuse. 3.) Staff has been	ì	
		P.M. Resident #A had			re-educated on the facility poli		
		ne facial features, and was			and procedure related to abus	е	
	non-responsive v	-			prevention, reportable		
		, op			occurrences and drug testing policy. DON/SSD or designee	will	
	Resident #A's red	cord was reviewed on			QA monitor abuse through		
	2/23/11 at 11:10	A.M. Diagnoses			random alert and oriented		
		re not limited to, Down's			interviewable resident interview	NS	
		ental retardation.			daily excluding weekends and holidays x 4 weeks, weekly x 4	ı	
	~)				weeks, then monthly x 2 month		
	Resident #A's sig	gnificant change			4. Results of QA reviews will	be	
	_	Set assessment, dated			forwarded to the Facility Risk		
		d Resident #A had			Management Quality Initiative, (RMQI), for further evaluation		
	=	arely/never understood			recommendations acted on as		
	-	y/never understood,			indicated. 5.) Allegation of		
	-	ye assistance of two			Compliance: March 25, 2011.		
	-						
	-	mobility, required total					
	-	persons to transfer, did					
	-	ed total dependence on 2					
	persons to dress,	-					
	dependence on 2	persons to toilet, and					

A BUILDING B. WING 155491 155491 155491 1202/24/2011	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX GEACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Was always incontinent of bowel and bladder. A copy of an incident on 2/7/11 at 9:30 P.M., provided by the Director of Nursing on 2/23/11 at 1:30 P.M., indicated the following facility investigation: Description of Incident - The Director of Nursing (DoN) received a call from confidential staff #1, indicating LPN #2 appeared impaired. The DoN arrived at the East facility building, and obtained a urine drug screen from LPN #2. The drug screen did not reach the required temperature range on the temperature strip. The DoN requested LPN #2 drink something in order to provide another urine sample. While waiting on LPN #2, the DoN received a message from confidential staff #3, indicating LPN #2 had catheterized Resident #A in order to	AND PLAN	OF CORRECTION		A. BUI	ILDING				
INAME OF PROVIDER OR SUPPLER LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Was always incontinent of bowel and bladder. A copy of an incident on 2/7/11 at 9:30 P.M., provided by the Director of Nursing on 2/23/11 at 1:30 P.M., indicated the following facility investigation: Description of Incident - The Director of Nursing (DoN) received a call from confidential staff #1, indicating LPN #2 appeared impaired. The DoN arrived at the East facility building, and obtained a urine drug screen from LPN #2. The drug screen did not reach the required temperature range on the temperature strip. The DoN requested LPN #2 drink something in order to provide another urine sample. While waiting on LPN #2, the DoN received a message from confidential staff #3, indicating LPN #2 had catheterized Resident #A in order to			155491	B. WIN			02/24/2	:011	
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the DoN received a message from confidential staff #3, indicating LPN #2 had catheterized Resident #A in order to			•						
had catheterized Resident #A in order to		the DoN received	d a message from						
		confidential staff	f #3, indicating LPN #2						
obtain a urine sample. Approximately 20		had catheterized	Resident #A in order to						
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		obtain a urine sa	mple. Approximately 20						
minutes later, LPN #2 reported to the		minutes later, LF	PN #2 reported to the						
DoN to provide another urine sample.		DoN to provide a	another urine sample.						
When LPN #2 provided the DoN her		When LPN #2 pr	rovided the DoN her						
urine sample, the DoN questioned LPN #2		urine sample, the	e DoN questioned LPN #2						
about the possibility the urine sample was		about the possibi	ility the urine sample was						
actually obtained from Resident #A. At		actually obtained	l from Resident #A. At						
first LPN #2 denied the allegation, then		first LPN #2 den	ied the allegation, then						
finally admitted the allegation was true,		finally admitted	the allegation was true,						
stating she "knew it was wrong and didn't		stating she "knew	w it was wrong and didn't						
know what else to do". The DoN		know what else t	to do". The DoN						
informed LPN #2 to count off her narcotic		informed LPN #2	2 to count off her narcotic						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

CG2511

Facility ID:

000316 If continuation sheet

Page 16 of 25

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155491			ULTIPLE CO LDING	NSTRUCTION	(X3) DATE COMPL	ETED	
		155491	B. WIN	IG		02/24/2	011
	PROVIDER OR SUPPLIER	EHABILITATION AND HEALTHO	ARE	1029 E	ADDRESS, CITY, STATE, ZIP CODE AST 5TH STREET ERSVILLE, IN47331		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	\top	ID	PROCESSES AND AN ADVANCE CONTRACTOR		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
	medications and	gather her belongings to					
	leave. The DoN remained with LPN #2						
		building. Type of					
	injury/injuries - The resident was assessed, and no redness, discoloration, or						
	_	The resident showed no					
		or behavior. Immediate					
		N #2 was escorted out of					
	-	ne DoN. Preventative					
		The MD was updated.					
	The resident had no responsible party to notify. LPN #2 was terminated. LPN #2						
	1 ^	d to the Professional					
		The first urine drug					
	screen from LPN	#2 would be sent for					
	laboratory testing	g. Resident #A would					
	continue to be m	onitored for signs and					
	symptoms of a u	rinary tract infection, and					
	changes in mood	or behavior, and staff					
		cated on the facility's					
	abuse and drug to	esting policy.					
		h the DoN on 2/23/11 at					
	l '	ated when she arrived at					
	1	ouilding the evening of					
	· ·	vith LPN #2 in the					
		and provided her with a					
		cup. The urine drug					
	•	by LPN #2 did not reach					
		perate on the temperature					
		LPN #2 a dollar, and					
	1 .	t something to drink, to					
	help her urinate.	The DoN indicated LPN					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155491		A. BUI	LDING	ONSTRUCTION	(X3) DATE COMPL 02/24/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE	02/24/2	J11
LINCOL	N CENTERS FOR R	EHABILITATION AND HEALTHO	CARE	1	ERSVILLE, IN47331		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	to the West facil another urine dru returned to the E conference room return, and provi While the DoN verturn to the conference a text mereceived a text mer	th the DoN on 2/24/11 at cated she should have #2 until she provided the g screen. The DoN 2 needed to get something need to smoke, and that is t LPN #2 would be doing to the West building to get					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) N	MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
THETETAL	or connection	155491	1	ILDING		02/24/2011	
			B. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				AST 5TH STREET		
LINCOLN	I CENTERS FOR R	EHABILITATION AND HEALTHO	ARE	CONNE	RSVILLE, IN47331		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
1110		seven components of		1110			BIIIE
		and management:					
	screening, training	_					
	identification, pro	otection, investigation,					
	and reporting Prevention - 1.) Ensure						
	that prevention to						
	•	the facility including, but					
		Ongoing supervision of					
		gh visual observation of					
		2.) Identify, correct, and ations where abuse,					
		nistreatment are most					
	likely to occur						
		mmediate safety of the					
		ipon identification of					
	-	neglect, mistreatment,					
	•	oriation of property					
	This federal tag i	s related to Complaint					
	IN00085926.						
	3.1-28(a)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 155491 02/24/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1029 EAST 5TH STREET LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE CONNERSVILLE, IN47331 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE F0281 Based on observation, interview, and F0281 F 281 SS: D Services Provided 03/25/2011 Meet Professional Standards It record review, the facility failed to ensure SS=D is the policy of this facility to the nurse followed ethical practices of the comply with Services Provided American Nursing Association in Meet Professional Standards. 1.) providing resident care. The deficient Resident A was re-assessed by Social Services and appropriate practice affected 1 of 3 residents reviewed actions were taken at the time. related to allegations of abuse in a sample Disciplinary action of staff was of 3. The nurse catheterized a resident to also completed as appropriate at use the resident's urine for the nurse's own time. 2.) Facility has conducted a review of a random sample of personal urine drug screen. (Resident charts and resident interviews to #A). ensure residents have remained free from Abuse. 3.) Staff has Findings include: been re-educated on the facility policy and procedure related to abuse prevention, reportable Resident #A was observed lying in bed on occurrences and drug testing 2/23/11 at 3:48 P.M. Resident #A had policy. DON/SSD or designee will Down's Syndrome facial features, and was QA monitor abuse through random alert and oriented non-responsive when spoken to. interviewable resident interviews daily excluding weekends and Resident #A's record was reviewed on holidays x 4 weeks, weekly x 4 2/23/11 at 11:10 A.M. Diagnoses weeks, then monthly x 2 months. 4. Results of QA reviews will be included but were not limited to Down's forwarded to the Facility Risk Syndrome and mental retardation. Management Quality Initiative, (RMQI), for further evaluation and Resident #A's significant change recommendations acted on as indicated. 5.) Allegation of Minimum Data Set assessment, dated Compliance: March 25, 2011. 1/18/11, indicated Resident #A had unclear speech, rarely/never understood others, was rarely/never understood, required extensive assistance of two persons for bed mobility, required total dependence on 2 persons to transfer, did not walk, required total dependence on 2

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155491			LDING	ONSTRUCTION	(X3) DATE COMPL 02/24/2	ETED	
NAME OF I	PROVIDER OR SUPPLIE	<u> </u>	_		ADDRESS, CITY, STATE, ZIP CODE		
				1	AST 5TH STREET		
LINCOLI	N CENTERS FOR F	REHABILITATION AND HEALTH	CARE	CONNE	ERSVILLE, IN47331		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	persons to dress	•					
	dependence on 2 persons to toilet, and was always incontinent of bowel and						
	bladder.	intiliciti of bower and					
	A copy of an incident on 2/7/11 at 9:30						
	1 1	by the Director of Nursing					
		30 P.M., indicated the					
	following facilit						
		ncident - The Director of					
	Nursing (DoN)	received a call from					
	confidential staff #1, indicating LPN #2						
	appeared impaired. The DoN arrived at the East facility building, and obtained a						
	urine drug scree	n from LPN #2. The drug					
	screen did not re	each the required					
	1 ^	ge on the temperature					
		requested LPN #2 drink					
	_	ler to provide another					
	1 *	/hile waiting on LPN #2,					
		d a message from					
		f #3, indicating LPN #2					
		Resident #A in order to					
		mple. Approximately 20					
		PN #2 reported to the another urine sample.					
	_	rovided the DoN her					
	_	e DoN questioned LPN #2					
		ility the urine sample was					
		d from Resident #A. At					
		nied the allegation, then					
		the allegation was true,					
	1	w it was wrong and didn't					
		-					

PRINTED: 03/18/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155491		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING				ETED	
		155491	B. WIN			02/24/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
LINCOLA	I CENTEDS EOD D	EHABILITATION AND HEALTHCA	\DE		AST 5TH STREET ERSVILLE, IN47331		
			1	<u>.</u>	.NOVILLE, 11147 33 1		are.
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
	know what else t	o do". The DoN					
	informed LPN #2	2 to count off her narcotic					
	medications and	gather her belongings to					
	leave. The DoN	remained with LPN #2					
	until she left the	building. Type of					
	injury/injuries - 🗆						
	· ·	redness, discoloration, or					
	_	The resident showed no					
	_	or behavior. Immediate					
		PN #2 was escorted out of					
		he DoN. Preventative					
		The MD was updated.					
		no responsible party to					
	-	was terminated. LPN #2					
	_	d to the Professional					
	_	. The first urine drug					
		I #2 would be sent for					
		g. Resident #A would					
		onitored for signs and					
		rinary tract infection, and					
	_	or behavior, and staff					
		cated on the facility's					
	abuse and drug to	esting policy.					
		1 /1 D M					
		th the DoN on 2/23/11 at					
	· ·	ated when she arrived at					
	1	ouilding the evening of					
	· ·	vith LPN #2 in the					
		and provided her with a					
	_	n cup. The urine drug					
	•	by LPN #2 did not reach					
		perate on the temperature					
	strip. She gave I	LPN #2 a dollar, and					
			<u> </u>				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CG2511 Facility ID:

000316 If continuation sheet Page 22 of 25

NAME OF PROVIDER OR SUPPLIER LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE DISTRICT ADDRIUS. CITY. STATE. JP. CODE: 1029 EAST 5TH STREET CONNERSVILLE, IN47331 SUMMARY STATEMENT OF DEFICIENCIES PRIBERY TAG REGULATORY OR IS CIDENTIFYNO INFORMATION) TAG requested she get something to drink, to help ber urinate. The DoN indicated LPN #2 also wanted to smoke. The DoN went to the West facility building to obtain another urine drug screen. The DoN returned to the East facility building conference room and waited on LPN #2 to return, and provide another drug screen. While the DoN waited on LPN #2 to return to the conference room she received a text message from confidential staff #3, indicating LPN #2 had catheterized Resident #A to obtain a urine sample. LPN #2 returned to the balthroom and returned with a urine sample. After several minutes of conversation, LPN #2 admitted she had straight catheterized Resident #A to use for her urine drug screen. An interview with the DoN on 2/24/11 at 10:00 A.M., indicated she should have stayed with LPN #2 atmit she provided the second urine drug screen. The DoN indicated LPN #2 recorded to get something to drink, and wanted to smoke, and that is what she thought LPN #2 would be doing while she went to the West building to get another drug screen. The American Nursing Association Ethics	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
INAME OF PROVIDER OR SUPPLIER LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE INAME OF PROVIDER OR SUPPLIER LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE INAME OF PROVIDER OR SUMMARY STATEMENT OF DEFICIENCIES PREETX (PACH DEPTICIENCY MIST BE PERCEDED BY PULL) PREETX TAG REGILATORY OR SEE DIMINITIVISM (INDOMATION) requested she get something to drink, to help her urinate. The DoN indicated LPN #2 also wanted to smoke. The DoN went to the West facility building to obtain another urine drug screen. The DoN returned to the East facility building to orienterine or many and waited on LPN #2 to return, and provide another drug screen. While the DoN waited on LPN #2 to return to the conference room she received a text message from confidential staff #3, indicating LPN #2 had catheterized Resident #A to obtain a urine sample. LPN #2 returned to the conference room, took the urine drug screen from the DoN, went to the bathroom and returned with a urine sample. After several minutes of conversation, LPN #2 admitted she had straight catheterized Resident #A to use for her urine drug screen. An interview with the DoN on 2/24/11 at 10:00 A.M., indicated she should have stayed with LPN #2 until she provided the second urine drug screen. The DoN indicated LPN #2 needed to get something to drink, and wanted to smoke, and that is what she thought LPN #2 would be doing while she went to the West building to get another drug screen.	ANDILAN	OF CORRECTION							
INCOLN CENTERS FOR REHABILITATION AND HEALTHCARE CASID			100.01	B. WIN		DDDECC CITY CTATE 7ID CODE	02/2 1/2		
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		The American N	Jursing Association Ethics						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

CG2511

Facility ID:

000316

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING		COMPL	ETED
		155491	B. WIN			02/24/2	011
		<u> </u>	D. (11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			AST 5TH STREET		
LINCOL	N CENTERS FOR F	REHABILITATION AND HEALTHO	CARE	1	ERSVILLE, IN47331		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
	web site at www.ana.org, indicated the						
	following: The nurse delivers care in a manner that preserves and protects clients autonomy, dignity, and rights. The nurse						
	seeks available resources to help						
	formulate ethica	-					
	101111alate cuilea	. 4001010110.					
	The most surren	t abuse policy provided					
	1 -	rator on 2/23/11 at 10:30					
		the following: Overview					
	1	s implemented processes					
		seven components of					
	_	n and management:					
	screening, training	ng, prevention,					
	identification, pr	otection, investigation,					
	and reporting	Prevention - 1.) Ensure					
	that prevention t	echniques are					
	implemented in	the facility including, but					
	1 ^	Ongoing supervision of					
		gh visual observation of					
		2.) Identify, correct, and					
	· ·	ations where abuse,					
		· · · · · · · · · · · · · · · · · · ·					
	1 -	nistreatment are most					
	1 -	Protection - 1.)					
		mmediate safety of the					
	_	upon identification of					
		neglect, mistreatment,					
	and/or misappro	priation of property					
	This federal tag	is related to Complaint					
	IN00085926.	-					
	3.1-35(g)(1)						
	<u> </u>						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING (X3) DATE SURVEY COMPLETED 02/24/2011				
		100491	B. WI		LIPPING GUILL GENERAL	02/24/2	
NAME OF P	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE AST 5TH STREET		
		EHABILITATION AND HEALTHC	ARE	CONNE	ERSVILLE, IN47331		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
					CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY) DEFICIENCY)	ATE	DATE